**MINUTES**

**JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES**

**December 8, 2010**
**Room 643, Legislative Office Building**

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) met on Wednesday, December 8, 2010 in Room 643 of the Legislative Office Building. Members present were: Senator Martin Nesbitt and Representative Verla Insko, Co-Chairs; Senators Austin Allran, Bob Atwater, Doug Berger, Charlie Dannelly, Jim Forrester, and William Purcell, and Representatives Jeff Barnhart, Beverly Earle, Bob England, Jean Farmer-Butterfield, and Fred Steen. Also in attendance was Representative Pat Hurley.

Lisa Hollowell, Joyce Jones, Shawn Parker, Jan Paul, Susan Barham, and Rennie Hobby provided staff support to the meeting. Also in attendance was Dr. Patricia Porter, consultant to the LOC. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Senator Martin Nesbitt, Co-Chair, called the meeting to order and welcomed members and guests. He asked for a motion to approve the minutes from the November 9, 2010 meeting. The motion was made by Senator Purcell and the minutes were approved.

Lanier Cansler, Secretary of the Department of Health and Human Services explained that DHHS continues to try to identify ways to achieve budgetary savings and that the options would be provided to State Budget for consideration. Points of interest included:

- Policy decisions will need to be made regarding the b-c Medicaid waiver – should Local Management Entities who elect to partner with other LMEs in the operation of the b-c waiver be contiguous and what DD Services will be managed by LMEs operating the b-c waiver.
- All divisions throughout DHHS will now use the same budget codes in order to help coordinate and perhaps consolidate management in various programs and services.
- By the end of the year there will be 944 operating State psychiatric beds across the state. There will be a minimum of 30 forensic beds on the Dix campus. A Request for Information has been issued for a possible private contract for the operation of the forensic beds. If the information gathered is positive, DHHS will contact other states speaking with advocacy groups, district attorneys, and others before any decisions are made to issue a Request for Proposal.
- In an effort to cut costs as leases expire across the county for State offices, space may be made available on the Dix campus temporarily for those employees until a decision is made regarding all the employees housed on the campus by DHHS. (There are currently 1,300 employees on the campus.)

- There are currently very few vacant positions in the state operated facilities. Positions at Dix are not being eliminated but rather moved to Central Regional and Cherry hospitals. Carpooling will be made available to reduce the cost of travel to Central Regional Hospital.
- The cost to maintain 100 beds at Dix is approximately $30M per year. There have been no budgeted funds for Dix in several years and funding has come from other areas in DHHS in order to maintain the facility. DHHS is still $15M over budget in operation of the facilities. Funding will have to come from community services in order to maintain the facilities. A new financial accounting system in the hospitals that will be in place by the next fiscal year will better identify costs in the hospitals to help save money. There will be 20 more beds next year; there are 265 fewer beds this year than 5 years ago; 140 community and voluntary admission beds have been added to community hospitals.
- The average cost for a community hospital bed is $750 per day. The average cost to operate a State facility bed is $1100-$1300 per day. The focus is on building community capacity in order to keep consumers closer to home, getting the professionals in place, and getting the crisis beds established in the community.

Secretary Cansler gave a lengthy explanation of why mental health reform has struggled since implemented. He explained that the area programs were divested of the delivery of services before the reform infrastructure was in place. The hospitals were losing money on their psychiatric beds and closing those beds to reduce costs. Professionals started to leave because of the lack of community capacity and the reliance on the State hospitals increased but funding was reduced. All budgetary and funding decisions were based on having 3 regional hospitals with community capacity in place. He said the idea is to move the short-term patients, roughly 40% of admissions, into community beds at $750 per day thus creating focus on the long-term patients. The design of the hospitals allows for future growth if there is a demand.

Peter Rives, Care Coordination Manager for CenterPointe Human Services LME addressed post-hospitalization continuity of care. He explained that CenterPointe linked people with services needed in their recovery. (See Attachment No. 2) Items of interest included:

- Patients referenced in data are those discharged from State hospitals with the exclusion of those going to jail, a medical hospital, or transferred to a different MH or SA facility.
- In the past, when relying on the Sheriff's Department, budget constraints and staffing limitations within the Sheriff's Department often meant patients discharged from a facility could not leave because of a lack of transportation.
- Response to problems in the past included partnering with Daymark Recovery Services which eliminated the lag time between a patient's discharge and follow up appointment. Consumers receive 2 appointments upon discharge, one with Daymark as a "check-in" and the other with any provider within the system.
- CenterPointe contracted with a private provider to transport patients. County discretionary funds pay for transportation.

- Peer Support is used to help engage individuals and help them develop a *Wellness Recovery Action Plan* (WRAP) which is a plan the individual develops for the future.
- An indigent lab program is funded for those individuals needing medication upon discharge and need lab work but do not have the means to pay for the service.

Mr. Luckey Welsh, Director of State Operated Facilities, DHHS, and Dr. Jeff Holden, Special Services Director at the Murdoch Center provided an insightful presentation on State Operated Developmental Centers. (See Attachment No. 3) Points of interest included:

- The facilities provide services and supports to individuals with intellectual and developmental disabilities (I/DD) and complex behavioral challenges and/or medical conditions whose clinical treatment needs exceed the level of care available in the community. Many units are designed as individual homes and cottages. Medical, dental, special therapies as well as adapted technologists are located on campus to provide the individual services and supports needed for each individual.
- All of the Centers have been downsizing for years. Persons who now live in the Center are older and with more significant cognitive, physical, medical and behavioral disabilities. No children are admitted to the Centers for long-term care.
- The Centers are mostly federally funded (95%-98%) with State funds amounting to 2%-5%.

Dr. Holden addressed specific programs at the Murdoch Center. Items of interest included:

- The DD Centers each have special differences from region to region mostly due to the response to different populations and an effort to be responsive to the LMEs and the consumers in their particular areas.
- Murdoch has worked closely over the past 10-15 years with other programs, LMEs, providers, the Autism Society, TEACCH, and other partners to develop specialized programs not offered in the community. The four specialty programs developed at Murdoch are ICF-MR certified drawing down Medicaid dollars.

Shawn Parker from the Research Division provided members with an overview of the presentations from the last three LOC meetings for discussion in preparation of the interim report to the General Assembly in January. He said noteworthy topics from those meetings are highlighted, and the items listed as potential topics for recommendations were noted as being of particular interest by members during conversations at those meetings. (See Attachments No. 4A and 4B). Members were asked to review these lists and provide any comments they have about potential recommendations to be added to the report to the Committee Chairs or to LOC Staff. It was suggested that the Committee discuss and vote on whether or not b-c waiver LMEs should be contiguous. Another possible recommendation was to require a report annually on the progress being made on evidence based services that are available for delivery in our State institutions.

Dr. Beth Melcher, Assistant Secretary for Mental Health, Developmental Disabilities and Substance Abuse Service Development, DHHS, addressed Mobile Crisis services. She explained that Mobile Crisis was one of the most critical services, responding to crisis needs in communities. (See Attachment No. 5) Points in Dr. Melcher's presentation included:

- Non-allocated non-UCR funds are State allocated dollars coming from the LMEs single stream funding which they designate for Mobile Crisis services. The allocation and the fee for service are not sufficient to support these services. The LMEs are needed for additional funding support.
- For those Hospital Emergency Departments that do not have psychiatric expertise, Crisis Teams collaboration helps offer structure and support to physicians with risk assessments, discharge and release plans for patients.
- Currently, there are Crisis Teams in all counties but in counties with a larger geographic area the response time can be longer. Additional response teams could reduce that wait.

Steve Jordan, Director of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services provided a follow up to last month's cost analysis and comparison of the ICF-MR and CAP/MR-DD services. Mr. Jordan referenced the ICF-MR state operated DD facilities verses the ICF-MR private community services and compared the ICF-MR services within the community and in the facilities with CAP/MR services. (See Attachment No. 6) Additional points during his presentation included:

- There are approximately 1,565 individuals in the State ICF-MR facilities and approximately 2,236 individuals in the community ICFs in over 327 facilities.
- Community ICFs-MR range in size from 6 beds per facility to over 100 beds and house both children and adults
- Medicaid expenditures are roughly 33% State dollars and 66% Federal dollars for services for children and adults.
- The largest children's ICF-MR facility has 124 beds.
- The graph of CAP-MR/DD Children and Adults depicts children 18 years and younger representing 19% of the CAP recipients receiving services and 42% of the other health related Medicaid-supported services in the CAP program. The Unduplicated recipient counts represent 33% of the children on the CAP waiver who receive 19% of the funding and represent 42% of the average cost per day.
- One of the differences between ICF-MR public facilities and ICF-MR private community facilities is that for community ICFs-MR the individual's Social Security room and board is built into the rate. The Social Security for individuals on the CAP Waiver is not included in the average CAP-MR/DD cost per recipient.
- Provider assessments (a provider funded rate enhancement) changes the cost for the State in the community based ICFs-MR.

Kelly Crosbie, Behavioral Health Manager for the Division of Medical Assistance discussed the changes to Medicaid Utilization Review (UR). (See Attachment No. 7) Ms. Crosbie explained the legislative mandate directing the return of UR of Medicaid funded services to the LMEs "when they are ready". She described the current MH, SA, and

CAP services and said that Value Options would no longer be responsible for any CAP-MR/DD reviews effective January 20, 2011. Other items of interest were:

- An RFA packet was sent to all LMEs and Crossroads, Pathways, Durham and Eastpointe were chosen to be UR vendors. Durham and EastPointe are already doing UR for all MH-DD and SAS and they, along with the other two LMEs, will now be responsible for all CAP-MR/DD reviews. The CAP-MR/DD UR for all the other LME counties will be split among these 4 LMEs on January 20, 2011.
- An effort was made to see that there are an equal number of Medicaid CAP Waiver recipient reviews going to each of these LMEs.

Ms. Crosbie was asked to provide a cost comparison for providing UR by the LME and the amount paid to Value Options. She stated that she would get the information to the LOC members.

Next, Ms. Crosbie gave an update on the Medicaid Waiver for Traumatic Brain Injury (TBI). (See Attachment No. 8) She explained that legislation requested that DMA and the Division of MH/DD/SAS study and report on the feasibility and cost of a 1915(c) or a home and community-based services waiver for people with TBI. Ms. Crosbie reviewed the TBI report submitted to the General Assembly on December 1, 2010 going over the purpose of the waiver, describing the target population, the cost projections, and the suggested service array.

Ms. Crosbie was asked if the military was included and if federal dollars or services were available. She was uncertain about the eligibility for when one could obtain federal funding for services but military personnel would qualify for the 1915(c) waiver. Flo Stein, with DM/HDD/SAS, said that those with service related injuries in a combat zone had full VA benefits. It was stated that the Institute of Medicine was studying the military and broad mental health service needs to include TBI. Representative Insko recognized member of the Traumatic Brain Injury Advisory Committee for their hard work on the TBI waiver study.

It was suggested that the subject of DD residential services for children 0-6 be addressed at the January meeting.

There being no further business, the meeting adjourned at 2:25 PM.

_____ _____

Senator Martin Nesbitt, Co-Chair Representative Verla Insko, Co-Chair

_____

Rennie Hobby, Committee Assistant